Congressman Kurt Schrader's Summary of H.R. 3200

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Healthcare Reform in the United States House of Representatives

Healthcare is getting increasingly expensive for everyone. Even those who are happy with their health coverage are finding it more and more difficult to afford. Individuals and businesses are dropping healthcare coverage because of its cost. Millions of Americans do not have healthcare and many of those that do still worry about losing their coverage or finding their insurance is inadequate.

Meaningful healthcare reform needs to address the concerns of access and affordability for taxpayers, businesses, providers and individuals. Everyone needs to have some shared responsibility for their own healthcare. No one should be denied care based on preexisting conditions or simply because you lost your job. Inefficiencies, waste and abuse in the current system need to be eliminated and competition to drive down cost should be encouraged. More emphasis needs to be put on preventative and primary care. Seniors should feel protected and reform must work to make Medicare more solvent. Reimbursement to providers should be based on getting good health outcomes, not the number of services rendered. Perhaps most importantly, people should have the best information available to make the best decisions regarding their own healthcare.

H.R. 3200 attempts to address these issues.

As your representative in Congress it's my responsibility to make sure my constituents have the best information possible on the major proposals being debated in Washington. This is my attempt to provide a relatively straightforward summary of the latest developments around H.R.3200. As always, please feel free to contact my office if you have any questions about the bill.

Healthcare reform revolves around guaranteeing everyone a basic level of healthcare in America. Every new or modified health plan 4 years from now must cover hospitalization, outpatient care, doctors and other health professionals, equipment and supplies needed for physician authorized care, prescription drugs, rehab services, mental health services, preventative services, maternity care and well baby and child care (including dental, vision and hearing up to age 21). A broadly representative Health Benefits Advisory Committee chaired by the Surgeon General will develop the details of the basic services with public input. Every individual and every business must share in the cost of their own healthcare services except the

extremely poor, (generally under 133% of poverty or about $14,400 for an individual) or the very small business with a payroll under $500,000 (originally $250,000, amendments proposed have raised the level).

Excluding Medicare, healthcare delivery in America will be through three major options regulated by an overarching Health Exchange to make sure the system is working correctly and everyone is playing by the rules. Private insurance will still provide the bulk of healthcare access in the House Plan. After 10 years the Congressional Budget Office estimates that employer based coverage does not change very much at 58% of healthcare coverage for Americans. Non-group and other health plans will cover 9%. A new 'Public Option' will cover 10% and Medicaid/Chip 16%. Approximately 7% will remain uninsured including unauthorized immigrants and those just not signing up.

All employers with a payroll over $500,000 must provide healthcare or pay a graduated payroll tax starting at 2% going up to 8% for higher payrolls. Small businesses with payrolls under $500,000 may provide healthcare for their employees but pay no tax if they choose not to. Very small businesses with 10-25 employees whose average wage per employee is less than $20,000 to $40,000 will be eligible for up to a 50% tax credit to help them provide healthcare coverage if they should so chose to do so. The employer would be responsible for 72% of the cost for his employee or 65% if also covering the employee's family. The employee would contribute the remainder as his or her fair share. Employers may opt to get their insurance under the exchange or with another private plan. Private and public plans are allowed under the exchange.

Individuals can get employer based healthcare through their employer as outlined above or get care on their own from either a private insurance company or a public option provider. If an individual does not get health insurance people he is penalized 2.5% of his adjusted gross income. 'Affordability credits' will be given to lower income individuals on a graduated basis with incomes up to 400% of poverty ($88,000 for a family of four), with non-employer based healthcare, to help them pay for their share of their health insurance. The government will help pay part of the premium for low income Americans, (more for extremely low income, less for those somewhat better off); to make sure that affordable healthcare is not beyond their reach. Out of pocket expenses above the premium are limited to $5,000 per individual and $10,000 per family adjusted for the consumer-price-index so that Americans are not one medical catastrophe away from bankruptcy.

The public option will be offered by 2013. It must compete on a level playing field with private plan choices. It will receive no taxpayer assistance other than a loan for start up costs which it has to repay over 10 years. It will have to negotiate its own rates (not tied to Medicare according to recent amendments), maintain reserves and pay its own administrative costs.

Childless, able bodied, poor adults (under 133% of the poverty level) are added to Medicaid with 10% cost sharing with the states. Medicaid and Medicare benefits are not reduced. Many efficiencies, productivity improvements and anti-fraud/waste measures are effected in the bill that save billions of dollars and provide better service for the individual, provider and insurer. The 'doughnut hole' in Medicare prescription drug coverage is reduced by 50% nearly immediately and completely phased out by 2023. Asset tests are eased, application and reimbursement improved and physician Medicare payments elevated so that physicians can afford to take on senior Medicare beneficiaries. Training and transparency in nursing home care is made a priority as well.

The bill recognizes that improving access requires investments in training and encouraging adequate primary and care providers to handle the increased caseload. The House bill encourages graduate medical education, expands loan repayment provisions for the national health service corps, recognizes America's rural needs for healthcare professionals (not all of whom have to be physicians), promotes training in family, general internal and pediatric medicine, geriatrics, dentists, physician assistants, dental hygienists and nurse practitioners. Scholarships and loan repayment programs are expanded for students aspiring to a career in primary care, especially in underserved areas.

Public health, community based health centers and school based health clinics are expanded. Preventative care strategies with evidence based results are to be developed. There will be no co-pay for preventative healthcare and primary care providers will be reimbursed for providing you preventative care and information at 100% of the cost. Expanded delivery of public healthcare and preventative care are recognized as ways to curb the long term healthcare cost curve thereby reducing costs to individuals and the system as a whole while providing a healthier life.

Oregon should benefit from the emphasis on quality not quantity of care embedded in the bill. Oregon and some other states have historically been penalized in their reimbursement rates from the federal government for providing high quality, low cost care. Forty years ago the original Medicare system was based on the "fact" that healthcare just costs more in some states. That is simply not true in today's national and global economy. An amendment to the base bill provides that over the next three years the federal government will transition from a strict fee for service payment schedule to one that recognizes good outcomes. Oregon will also benefit from the emphasis on accountable care organizations, medical home delivery systems, pay for performance incentives, evidence based research on best procedures, medications and delivery systems because we are already pioneering in these areas.

How do we pay for this reform? About half of the cost of the House healthcare bill would come from efficiencies in our current Medicare and Medicaid system as referenced earlier. The other

revenue source currently is suggested to be a surcharge on those families earning over $350,000 adjusted gross income ($280,000 for an individual). It is estimated that the surcharge would apply to only the top 2% of earners today.

The Congressional Budget Office (CBO) has not responded favorably to the House Bill controlling long term costs. CBO has concerns that the bill as originally written actually increases long term costs given the improved access and subsidies given to individuals and businesses. However, CBO does not give credit in its cost containment formulas for the potential long term benefits of improved public health, preventative care, and moving to a quality based versus quantity based reimbursement methodology for providers. Nevertheless, the long term cost issues identified by the Congressional Budget Office need to be addressed before final passage.

Currently, H.R. 3200 has been voted on by the three committees with jurisdiction in its' development. A combined single bill is being developed during the August work period and final cost predictions will accompany that draft. The House will have an opportunity to further refine the bill as it comes to the floor for a vote after the August work period with the input of many of you.